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A Gendered Analysis of Labour Market Informalization and Access to Health in Chile

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ABSTRACT Health sector reforms across Latin America are replacing the concept of risk-sharing across the population with more individualized approaches to accessing health care, and health insurance schemes have been advocated by the World Bank as a means of helping poor people overcome the risk of ill health. Yet at the same time the lowering of labour standards and the growth of informal workers means that for an increased number of workers, contributing to a health insurance scheme is not feasible. Drawing on evidence from Chile this article examines the gendered dimensions of these processes and highlights the ways in which the gender division of labour means that women are more adversely affected than men.

KEYWORDS *Chile, gender, health, informal workers*

Introduction

Defining globalization continues to be a contested area (Scholte, 2005), but it can be understood as the process of integration of a large number of developing countries into the global market since the 1980s and the concurrent changing structure of trade, whereby many low income countries have harnessed their labour abundance to give them a comparative advantage in labour-intensive manufacturing and service provision. Several factors account for this shift, including programmes of financial and trade liberalization undertaken in a large number of developing economies as well as improvements in global communications and transport (World Bank, 2002).

Discussion of the link between macro-economic change and social welfare is not new within the development literature (Cornia et al., 1987) but it has been generally absent from globalization discourse. Despite the growing debate around globalization and health (Cornia, 2001; Dollar, 2001; Lee et al., 2002), little attention has been given to the gender dimensions of these linkages. Nevertheless, in recent years a small but growing body of work has emerged to address some of these issues. Within this literature there is a general consensus about the main dimensions of globalization that are likely to have a gendered impact on human well-being (Benería, 2001; Doyal, 2002; Evers and Juárez, 2001; Harcourt, 2001). In particular two specific concerns have emerged.

First, increased levels of women's employment combined with lower labour standards have created new health risks. Meanwhile, health sector reforms across Latin America are replacing the concept of risk-sharing across the population with more individualized approaches to accessing health care.¹ Yet the lowering of labour standards means that many workers do not have access to health insurance schemes, though this has been advocated as an essential mechanism for helping people to manage risk and cope with adverse shocks, such as ill health (World Bank, 2000). In the current context of labour market informalization it is not clear that this is a real possibility for many households.

Second, women's increased participation in paid work combined with what has been termed 'the squeeze on care' (UNDP, 1999) as cuts in state-provided welfare continue, have placed considerable strain on women's 'double burden'. Studies have shown that many of the contradictory processes of globalization have actually increased the vulnerability of some households, making them less able to deal with shocks and overcome risk (Aslanbeigui and Summerfield, 2001; Benería, 2001). Research has highlighted the ways in which many of the costs associated with economic reforms can be transferred onto households, where they are mainly absorbed by women (UNDP, 1999). As studies have shown, this has clear implications for the health and well-being of women and their dependants (Elson, 1995; Sparr, 1994) yet these concerns remain pertinent.

The analysis presented here will consider these issues within the context of the Chilean health sector. The Chilean case is a particularly important one, given its reputation as the great success model of health reform in Latin America (Laurell, 2000; Taylor, 2003). Clearly, gender is not the only variable that affects ill health – class, race and ethnic difference are also important – but it is the interaction between gender and other social determinants that is the focus of the discussion here. In particular it is the interaction between gender and poverty that is highlighted, since this can create multiple barriers to women's well-being.

The article starts with a discussion of the Chilean context and briefly outlines the background to the growth of women's employment and labour market informalization, as well as the process of health sector reform. Using a

‘gender lens’ the analysis considers some of the factors that restrict access to health care, particularly for informal workers, and highlights some of the new occupational health concerns that have arisen as a result of new forms of employment in Chile. In the next section the discussion focuses on the gender division of labour in Chile and the squeeze on care as many of the costs of health sector reforms are transferred onto households. Some of the strategies used by people to access the health sector are also examined. Finally, some conclusions are drawn.

The Chilean Context: Economic Restructuring

Between 1973 and 1990, under the dictatorship of General Augusto Pinochet, Chile experienced comprehensive economic restructuring, including within the health sector (Reichard, 1996). The foundational phase of the reforms, from 1973 until 1983 saw a shift away from an era of state-led development via the implementation of a series of structural reforms oriented towards a more open, market-led economy. An integral element of these reforms was a drastic and rapid reorientation of the role of the state, particularly in the economic and social arenas. The state would only perform activities that could not be carried out by the private sector because they would impinge on the security of the country or were beyond the realms of capability of the private sector (Borzutzky, 2002). While many of these policies may have made economic sense, they were implemented without any social safety nets and consequently the social costs were very high. This is reflected in Table 1, for example the growing levels of unemployment in the first decade of the reforms. The second phase of reform was characterized by a period of ‘fine tuning’ of the neo-liberal model and the creation of new socio-economic networks and the introduction of measures to create export-led development (Martínez and Díaz, 1996: 47). It is also important to note that Pinochet’s regime was characterized by widespread repression and abuse of human rights in order to eliminate any opposition, and while this remained a constant threat throughout the regime it was most severe during the early years (Borzutzky, 2002).

Poverty levels increased, particularly during the first decade of reforms, as the effects of the policies spread (Raczynski, 1994) and critics have highlighted the role of women’s unpaid work in absorbing the costs of the new model (Montecinos, 1996). Table 1 shows some social indicators for the period.

During the military regime export production increased considerably – rising from 20.4% of GDP in 1974, to 24% in 1984 and reaching 37.3% in 1995 (Martínez and Díaz, 1996: 52). Although the foundations can be traced back to the 1960s, the expansion of the fruit exports became a central tenet of export development under Pinochet. Agrarian ‘counter reform’ forced large numbers of peasants to leave the land and stimulated the expansion of a private commercial farming sector in the central region of the country – the volume

TABLE I *Select social indicators, 1974–2000*

<i>Indicator</i>	<i>1974–81</i>	<i>1982–84</i>	<i>1985–89</i>	<i>1990–2000</i>
Unemployment (% of labour force)	16.9	27.4	14.2	7.6
Average salary (1970 = 100)	75.7	90.1	86.7	115.8
Poverty level (% of population)	n/a	n/a	45.1	27.4
Income distribution 5th quintile/1st quintile	14.3	17.8	18.8	14.9
Social expenditure (1970 = 100)	78.3	97.2	86.4 ^a	115.6

Source: Ricardo French-Davis and Barbara Stallings (eds), *Reformas, crecimiento y políticas sociales en Chile desde 1973* (Santiago, Chile: Economic Commission for Latin America and the Caribbean (ECLAC)/Ediciones LOM, 2001) p.51, Table 5.1.

Note: ^a Public expenditure decreased until 1987 when it reached 61 and averaged 86 for the years 1985–89.

of fruit exports increased by 256% between 1982 and 1992 (Barrientos et al., 1999: 3). Since the return to democracy in 1990 export-led development, particularly horticulture, has remained central to government policy. Important changes to the labour market also occurred. Following a brutal repression of trade unions and deregulation of the labour market, a new labour plan was introduced in 1979. It facilitated the type of flexible working patterns that are the focus of this analysis, for example through replacing the existing system of collective contracts with a model of individual contracts, which increased the ability of firms to impose changes in organizations and encouraged subcontracting and increased temporary or fixed-term contracts. At the same time the state policy of reducing the importance of the minimum wage allowed the erosion of any fixed components in wages and increased the scope for labour cost variations (Martínez and Díaz, 1996: 61).

In 1990 the country returned to more democratic forms of government through a process of democratic transition that has been broadly criticized because of its top-down nature and failure to address human rights issues (Cammack, 1994). The introduction of the so called organic-constitutional laws by the military government prior to the transition ensured the continuation of authoritarian enclaves in the future political regime, for example through determining the structure and autonomy of the Central Bank and forbidding government intervention in the decision-making process of the organization, while another law prohibited Congress from investigating human rights abuses (Borzutzky, 2002: 198). Similarly, electoral laws gave right-wing political parties a sizeable parliamentary representation that led to the formation of a right-wing coalition between parties and in the long term gave the right a veto power over constitutional reforms that has prevented any changes to the 1980 Constitution designed by the military regime (Borzutzky, 2002: 243).

In line with broader macro shifts in the hegemonic development model, the Chilean governments of the 1990s recognized a greater role for the state in development, including increased social responsibilities as a central component of the post-Pinochet project of social and political integration. Yet successive governments in the 1990s continued to define the rights and obligations of clients in market terms (Schild, 2002: 171). Social assistance remains targeted to 'the poorest of the poor' and there has not been a return to universalist principles of service provision of the pre-Pinochet era (Molyneux and Razavi, 2002: 23). Moreover, despite overall improvements in living standards, inequality remains high – the Gini Coefficient has remained at around 5.4 since the late 1980s and income levels of the wealthiest 20% are around 17 times that of the poorest 20% of the population (World Bank, 2001).

Health Sector Reform

Within the health sector attempts were made to reduce the role of the state, expand the private sector in provision and financing, and introduce a series of market mechanisms for resource allocation and promoting decentralization within the public sector. In 1981, despite widespread opposition, private insurance companies, the *Institutos de Salud Previsional* (ISAPRES), were established that could compete with the social health insurance system for affiliates, creating two parallel sectors for financing and provision. In 1986 pre-existing differences in provision between blue- and white-collar workers were completely eliminated with the establishment of a uniform compulsory health insurance contribution of 7% of earnings. The *Fondo Nacional de Salud* (FONASA) was created to collect the contributions of those affiliated with the public sector and allocate resources to providers (Barrientos and Lloyd Sherlock, 2000: 418). The reforms generated large inequalities in access and provision and cuts in government funding, as demonstrated in Table 2, and resulted in a deterioration of the public sector (Scarpaci, 1991).

The Coalition governments of the 1990s continued to reform the health sector and considerable emphasis was placed on rebuilding the public sector and improving the efficiency and quality of health care. Health expenditure increased throughout the 1990s, rising from 14% of public expenditure in 1990 to 21% in 1997 (Pan American Health Organization [PAHO], 1999: 8). Per capita health expenditure is currently around US\$700.²

In 2000, with the election of President Ricardo Lagos, the first Socialist President in Chile since 1973, expectations were raised that he would work towards creating a more participatory and equitable society. Reform in the health sector has focused on improving access to health care for the lowest income groups and in 2002 the Plan for Universal Care with Explicit Guarantees (AUGE) was introduced. This was intended to improve access to and quality of services for more complex health conditions. Fifty-six conditions

TABLE 2 *Public expenditure on health as 2% of GDP, 1974–88*

1974	1975	1976	1977	1978	1979	1980	1981
3.21	3.38	2.94	2.91	2.90	2.70	2.60	2.93
1982	1983	1984	1985	1986	1987	1988	
3.53	2.94	2.88	2.65	2.53	2.33	2.40	

Source: Reprinted with permission from Ernesto Miranda, *La salud en Chile: Evolución y perspectivas*, (Santiago: Centro de Estudios Públicos, 1994), p. 77.

were included in the proposals. Health care for these selected conditions will be free to indigents and the lowest income groups while the remainder of the population will have to pay a proportion of the cost, although additional co-payments may be applicable. Since July 2005 treatment for 25 conditions has been guaranteed and the government hopes that treatment for the remaining conditions will be guaranteed by the end of 2007.³ However, expectations have not been met and the proposed reforms have attracted considerable opposition from both the left and right (Revista Punto Final, 2002).

The Health System

Today, Chile has a mixed insurance system where workers can choose between the public (FONASA) and private (ISAPRES) sector to contract their mandatory 7% health insurance contributions (Jimenez de la Jara and Bossert, 1995; Miranda, 1994). Within FONASA, entitlements depend upon earnings-related contributions and contributions finance the benefits provided. The lowest income groups are entitled to free care directly from FONASA, but are only eligible for certain services and a number of important exclusions exist (Bitrán et al., 2000). Around 60% of the population is in FONASA, while the remainder is either in an ISAPRES or covered by special social insurance funds, such as those for the armed forces and police (Pollack, 2002). A small percentage is not covered by any health insurance plan.

The privatization of health insurance initiated under Pinochet subsequently opened the way for foreign investment in the health sector, as multinational corporations bought up the ISAPRES companies or entered into joint ventures with Chilean companies. Many of the companies that currently own the Chilean ISAPRES companies are subsidiaries of large US and European insurance corporations (Iriart et al., 2001). This raises important questions over the ability of the state to effectively regulate the ISAPRES. As Mackintosh (2003) warns, commercialization of the health sector has important implications for poverty and equality issues and this is becoming manifest in Chile. One example is the problem of 'cream-skimming' (Sapelli, 2004), which remains an issue

within the ISAPRES, whereby those with lower risks are 'skimmed' by the private sector, leaving those with higher risks in the public sector. Furthermore, in many cases where people do develop health problems that require complex (and expensive) care, they cannot afford the additional co-payments required under the ISAPRES and so transfer back into the public sector, making FONASA the provider of last resort. In effect, privatization embeds inequality, as health care itself is restructured as internal hierarchies are reworked and the pattern of those treated and excluded is reshaped (Mackintosh, 2003: 6). Moreover, there is clear gender discrimination within the ISAPRES. A recent study by Pollack (2002) found that women of reproductive age have to pay two or even three times as much as men for a health plan. However, this is often justified by the ISAPRES companies in terms of women's tendency to take more sick leave than men (often as a result of their role as prime caregivers within the household) (Organización Panamericana de la Salud/Organización Mundial de la Salud [Pan American Health Organization/World Health Organization] [OPS/OMS], 2002:19). The issue of gender bias is discussed in more detail later in the article.

Not surprisingly the majority of ISAPRES members are men aged between 25 and 49 – in 2001 only 32% of ISAPRES members were female (OPS/OMS, 2002: 13). Moreover, nearly one quarter of ISAPRES users continue to use the public sector for certain services, since they cannot afford the co-payments required for additional services (Iriart et al., 2001).

Labour Market Informalization and Women's Employment

The implications of global economic restructuring and especially trade and investment liberalization for production processes are well documented. Attention has been given to the subsequent changes created in labour markets and the increased levels of female employment across Latin America and beyond (Division for the Advancement of Women, Department of Economic and Social Affairs [DAW], 1999; Standing, 1999). In Chile although the overall rate of women's participation in the labour force is relatively low for the region, it rose from just over 25% of the total labour force in 1976 to almost 34% in 1995 (Frohmann and Romaguera, 1998) and to 42% in 2000 (Instituto Nacional de Estadísticas [National Institute of Statistics] [INE], 2002).

Although new employment opportunities have been created, the quality of these new jobs is not always clear since they are often not regulated or protected. Recent economic growth has been associated with flexible labour markets, outsourcing of production and the growth of temporary and part-time jobs. Governments often fail to acknowledge the social outcomes of such policies in terms of poverty and gender inequality and fail to initiate safety nets of unemployment compensation schemes (United Nations Development Fund for Women [UNIFEM], 2005).

As a consequence there has been an unprecedented expansion of the informal economy in recent years.⁴ To increase global competitiveness many investors have moved to countries with lower labour costs or shifted to informal employment arrangements. In addition there has been a dramatic restructuring of production and distribution in many key industries, characterized by outsourcing or subcontracting through global commodity chains. This has meant that an ever growing number of workers are being paid very low wages and many of them have to absorb the non-wage costs of production (Carr and Chen, 2002: 2), as has occurred in the textile and clothing industries in Chile since the early 1980s.

Although the connection between this growth of informal work and the large numbers of women entering paid employment is still subject to debate (UNIFEM, 2005), what is clear is that the majority of informal workers, and especially home-based workers, are women (Carr et al., 2000; Chen et al., 1999; Pearson, 2004; Prugl, 1999). An International Labour Organisation (ILO) study estimated that 84 out of every 100 jobs created in Latin America during the 1990s were in the informal sector (Munck, 2004: 5). This increase in informal workers raises important concerns from a health and social policy perspective since many lack access to social protection and health insurance schemes.

Home-based work is work that is done in or around the home for a cash income but within this broad definition different categories of home-based workers can be identified (Pearson, 2004). Not only are a higher percentage of economically active women than men located in the informal economy but the gender gap in wages appears to be higher in the informal economy than in the formal economy:

There is, as a result, an overlap between being a woman, working in the informal sector and being poor. A higher percentage of people working in the informal sector, relative to the formal sector, are poor. This overlap is even greater for women than for men. (Carr et al., 2000: 127)

In Chile there are around 80,000 home-based workers, around 66,000 of whom are women. Data also reveals that female home-workers are younger than their male counterparts and that around 61% of female home-based workers are aged between 25 to 44 years old (Henríquez et al., 2001: 41). The majority of home-based workers in Chile are located in urban areas although around 4% are situated in rural areas. In both urban and rural areas the main activity of home-based workers relates to the promotional sale of products and services. In urban areas this is followed by garment manufacture and technical work such as typing or data inputting; in contrast in rural areas the most prominent activities are processing or work involving agricultural products and craftwork (Henríquez et al., 2001: 18).

Factors Restricting Access to Health Care

Debate continues around the contradictory tendencies surrounding the increase in women's employment (DAW, 1999). From a health and social policy perspective there are specific concerns. Although in many developing countries the creation of new forms of employment has actually increased individual autonomy for many women workers, at the same time they are subject to discrimination and exploitative working conditions and are often in effect denied access to welfare provision. The variable nature of subcontracted work and salaries makes it difficult for households to make regular contributions required by health insurance plans (Benería, 2001). This is particularly the case for home-based workers who have no regular employment contract, wage agreement or regular working hours, and their work is invisible to others, particularly policy makers and government agencies (Pearson, 2004). Since women are more likely to be employed in this type of work this suggests that women are less able to access health insurance plans than men.

One important factor that limits women's access to health care compared to men is the gender gap in wages. In Chile this is not confined to informal work and is found across all sectors of the economy. Women in all socio-economic groups earn up to 30% less than men (Vega et al., 2003). Rates of unemployment are higher among women (9.4%) than men (7.9%) (Díaz and Medel, 2002: 2), so this gap may be even greater for those employed in the informal sector. Consequently fewer women than men contribute to health insurance plans – 34.3% of women compared to 36.1% of men (Díaz and Medel, 2002). Women's lower wages have been identified as a key constraint in limiting women's access to the ISAPRES (OPS/OMS, 2002; Pollack, 2002; Ramírez, 1997). Yet as out-of-pocket expenditure and other health-related expenditure rise the implications of this go beyond limiting women's access to the private sector.

Over the last few decades Chile has seen an increase in flexible working hours and part-time work, although it is important to differentiate between different types of part-time work that offer different sets of advantages and disadvantages to women and men and not to confuse, for example, flexible working hours for employees with imposed flexibility by firms (Rubery et al., 1998: 80). Much of the expansion of flexible working in Chile, particularly in the service, financial and agricultural sectors, has been of the latter sort (Díaz, 2004). An extensive study conducted by the Centro de Estudios de la Mujer, a feminist research institute based in Santiago, found that workers are often paid daily or hourly rates but were denied regular salaries and many, especially in the financial sector, were asked to work fixed hours but were paid on a commission basis according to the number of financial products sold, and often worked beyond the contracted hours in order to meet targets set by the company and earn sufficient income to live off. They were not paid for overtime. Similarly, home-based workers in the clothing industry worked long hours that surpassed the

normal working week of 48 hours in Chile and in periods of high demand the women often worked through the night and over the weekend in order to supply clothing. Nevertheless since they were paid on a piecework basis they were not given any additional pay. Moreover the majority lacked contracts, working instead according to verbal agreements and so were not entitled to any form of social protection or health insurance (Díaz, 2004).

Although many part-time workers in Chile do lack access to health insurance they often have no alternative but to take jobs that only offer limited hours. The 2002 National Employment Questionnaire found that a large proportion of part-time workers employed for less than 35 hours a week wanted to work more hours, and this was especially true for women. Forty-four percent of men and 55% of women working part time wanted to work more hours and the majority of women included in this group were aged between 25 and 44 years of age. This suggests that people are not choosing to work part time but are not able to find an alternative; other research has shown that women also opted for this type of work mainly because of their unpaid reproductive responsibilities, whereas men did not face this restriction (Díaz, 2004: 158). Moreover, although women often take on such jobs with the belief that they will be able to combine the reduced hours with other caring responsibilities, they are frequently forced to work for intense periods of time in extended shifts, through the night, or over weekends and public holidays, and so in effect are not able to effectively combine their paid and unpaid roles. This pattern of working hours was most common in the financial and commerce sectors, both female-intensive sectors where most growth of part-time work has occurred. In 2002, around 17% of all female employees and only 7% of all male employees in the commercial sector worked less than 34 hours per week, i.e. were employed on a part-time basis. These long working hours can have negative impacts on women's sleeping and eating habits, which clearly have important implications for both physical and mental health and well-being. Given the relatively rigid gender division of labour in Chile (described later) it also means that many of the women have little time to recuperate after working extended shifts or night shifts as they need to continue with their caring responsibilities, including breastfeeding (Díaz, 2004).

Lack of health provision is cited as a major issue by many informal workers. Indeed in a recent international mapping project, coordinated by the UK-based home-working non-governmental organization (NGO), Homeworkers WorldWide, homeworkers specifically raised this as a concern (Tate, 2003). The Chilean element of the research conducted by the home-based workers NGO CECAM interviewed over 1500 workers (mainly female) and found that the majority of the respondents did not have any sort of health plan.⁵ In some cases women were registered as a dependant of their husbands, although this points to the issue of 'male breadwinner bias' (Elson and Cagatay, 2000) and many of these women complained that not being able to access health insurance in their own right reduced them to the status of a child or an indigent

(Pearson, 2004: 146). Where women did not have male partners they were forced to register as indigents. Many of the women interviewed felt that this lowered their self-esteem and that they were badly treated by health staff because of their low status. They believed that the health workers saw them as 'lazy women' who stayed at home rather than earning a living, yet this was not the case. They could not admit to having a job since this would disqualify them from accessing the system.⁶ This links to broader issues of social exclusion and points to the ways in which many poor people can associate bad experiences of the health care system with their own poverty and powerlessness (Tibandebage and Mackintosh, 2001).

Registering as an indigent also restricts users' access to certain benefits. In the public system in Chile although indigents are entitled to access basic services, several exclusions apply. For example, they are not entitled to income subsidies during pregnancy – three months prior and two months after the birth of the baby – and they are also excluded from illness-related income subsidies (Bitrán et al., 2000: 176).

Rural Workers and Temporary Workers

Since 2002 special arrangements have been made for temporary workers to improve access to the public health system – after only 60 days of salary contributions they are entitled to free outpatient and secondary health care as well as basic primary care for 12 months. However, there is still a significant percentage – 13% of female and 20% of male temporary workers – that do not. Yet while women are more likely to have some kind of health coverage than men this is probably because many female temporary workers are registered as dependants on male partner's health plans, rather than being registered in their own right, or may have partners who earn better incomes than they do (Hernández and Montero, 2004: 17).

Nevertheless there are still a number of concerns that need to be addressed. While the fruit and horticulture sector provides a large number of jobs for both men and women in rural areas, men are more likely to be employed on permanent contracts, while women are mainly employed as temporary fruit pickers (*temporeras*). Given the difficulties of measuring temporary employment and especially women's underestimation in it, Barrientos (1997) has shown that of just under 350,000 fruit workers in Chile, 85% are temporary workers and of that, 52% are female, and only 5% of women have permanent jobs. Data from the 2000 national household survey, the CASEN (La Encuesta de Caracterización Socioeconómica [National Survey of Socioeconomic Characterization]), shows that nearly 40% of all temporary workers do not have a contract (Hernández and Montero, 2004: 6). Yet while around 18.6% of male fruit workers do not have a contract this rises to 24% for women (Díaz and Medel, 2002: 2). Moreover, around half of *temporera* households have no members

with permanent stable employment and have per capita household incomes below the poverty line (Barrientos and Barrientos, 2002).

Occupational Health Issues

Historically men have been more at risk from occupational health hazards but the changing nature of employment has created new and different risks for women (Doyal, 2000; Hale, 1999). The expansion of horticultural exports in Chile and elsewhere, where the labour force is mainly female, has brought higher incomes for women workers but also new health hazards and increased workloads (Barrientos, 1997). The high use of pesticides in the agricultural export sector can mean workers face a range of physical and mental health risks, including nausea, birth defects and acute depression (Dolan et al., 1999).

In Chile, studies have shown that there is a high incidence of alcohol and drug consumption (prescription and non-prescription) among *temporeras*, high rates of mental illness, and higher rates of child malformation have been observed in fruit growing areas (Barrientos and Barrientos, 2002). The Pan American Health Organization estimates that around 2m workers lack access to any occupational health protection and that a large number of workers,⁷ particularly unskilled and temporary workers, only have limited access. Since women are less likely than men to have a contract they are unlikely to be eligible for sick pay and are not covered by Law 16.744, which legislates against work-related illness and accidents. This also means that any occupational health problems that do arise for this sector of the population are not recorded and this has important policy implications. In practice, workers without contracts are forced to weigh the consequences of not seeking health care or taking time off and risk losing wages or even their jobs. Given the gendered distribution of informal workers and the gender division of labour in Chile it is usually women who have to make these decisions, especially where they are responsible for the health of dependants (Gideon, 2001).

Furthermore, there are important urban–rural disparities in the Chilean health system and many rural health services are relatively underfunded. One study has shown that municipalities allocating the highest per capita funds are not the ones with the greatest health needs and outpatient and inpatient medical care shows considerable geographic variations (Arteaga et al., 2002). Research has shown that rural health care resources are not always allocated in transparent and accountable fashion, whereas this is less likely to occur in urban areas (Atkinson et al., 2005). In addition it can be problematic attracting and maintaining doctors and health professionals to work in rural health services, particularly those in more remote locations. These issues raise important concerns regarding the specific ability of health services to respond effectively to the needs of rural users.

Occupational health risks have also been identified in relation to other new forms of work. In the CEM (Centro de Estudios de la Mujer) study, (Díaz, 2004) women working as data inputters reported repetitive strain injuries and physical complaints related to spending long hours at a computer. Since they were paid on a piecemeal basis they were forced to work very intensively, compounding many of their physical complaints. In effect they were not able to take sufficient breaks as this would hinder them from reaching their targets. Moreover, although the women did have some form of employment contract that covered them for occupational health problems, since they were paid on a piecework basis they were not entitled to sick leave or maternity leave (Díaz, 2004: 114). Similarly many of the home-based workers in the CECAM study reported health problems relating to a range of poor working conditions, including sewing with insufficient light, exposure to toxic chemicals contained in the glue used to stick leather goods and carrier bags, and repetitive strain injuries.⁸

The Gender Division of Labour and the Squeeze on Care

The deterioration of service provision has meant that households and local collectives have increasingly taken over (or taken back) roles and functions that were previously located in the formal health care sector (Bloom and Standing, 2001). In Chile a wide range of health-related activities are carried out unpaid by household members, mainly women. These include caring for convalescing family members once they are discharged from hospital, looking after critically ill family members, preparation of special diets, administering of certain treatments, buying necessary drugs and other specific requirements, and preparation of food and laundry for family members who are hospitalized (Proveste and Bergosky, 2002). This has resulted in 'a squeeze on care' as the resources available for the provision of care, not only unpaid care but also care services provided through the public and private sectors, has been constantly squeezed as a result of intensified international competition (UNDP, 1999). The prevailing gender division of labour means that despite their increased role in the paid economy, women rather than men usually have to bear the costs of this. The role of women as 'social shock absorbers' has long been acknowledged in feminist literature and more recently evidence suggests that globalization has not reversed this trend (Grown et al., 2000). Despite women's increased time spent in the paid economy the gender division of labour in Chile has remained relatively rigid (PNUD, 2002). Even though some men are increasing the amount of time they spend carrying out childcare and other reproductive responsibilities, the bulk of the work is still carried out by women (Olavarria, 2003).

Moreover, research suggests that the poor commonly manage the cost of sickness by extending the threshold of seriousness at which they seek treatment

(Bloom and Standing, 2001), implying an absorption into the household of the care and management of such individuals (Pearson, 2000: 231). Evidence from Chile has highlighted that women, particularly when they are employed as informal workers, often fail to look after their own health as they feel that they do not have time to spend in bed if they are ill and cannot afford to lose wages (Díaz, 2004). And while some women are able to depend on other female relatives for help, men rarely contribute to this work (Gideon, 2001). This is an area that urgently requires further research, especially since critics have argued that many of these activities will increase under proposed reforms to the health system (Proveste and Berlgoscky, 2002).

In reality, households engage in a complex web of non-market and market transactions in getting access to health resources and a number of studies record substantial borrowing from commercial sources to offset the cost of major illnesses. This is potentially problematic for many part-time and informal workers, especially women, since gender norms often mean that they lack equal access to loans and other forms of credit. Indeed in the CEM study (Díaz, 2004) lack of access to credit was an important concern for the part-time workers in the financial sector who were interviewed. As one female respondent stated in reference to her job selling financial products:

We are discriminated against and ... are looked down on. At a bank, if you go and ask for a loan they ask why you are only a salesperson. There is an important social cost that you have to bear, there are problems with getting a loan and also problems with joining an ISAPRE. The worst is if you are a woman, and worse still if you are a pregnant woman, a pregnant financial salesperson is the most discriminated against. Banks also discriminate against us because of our variable income. (translated by author, cited in Díaz, 2004: 109)

One common response in Chile for those who do not have any health insurance or who wish to use the private sector but are unable to join an ISAPRES is to pay for individual services. There are a large number of private providers where users can have one-off consultations and pay directly for the services they use without having to possess private health insurance. However, very often while people are able to pay for the first consultation and even any initial tests that may be required, they often lack the necessary resources to continue with treatment and so abandon it, leaving their health problems unresolved (Gideon, 2001). Moreover, since many small-scale private providers are unregulated, this raises concerns about the quality of care under some of these providers. The decentralized Health Services are responsible for regulating the private sector but many private practices are set up in agreements with the municipality, hence the agreement is made between the municipality and the individual and the Health Service does not play a role in this. In reality the Health Service does not even know how many private practices operate in their area, and they are not in any way able to monitor the quality of service provided.⁹

Conclusions

This article has identified some of the specific ways in which the informalization of the labour market in Chile has made it more difficult for certain sectors of the population to access health care. This process has been made more difficult as a result of the ongoing privatization of the health sector and the increased shift towards individualized health insurance programmes. Given the gender division of labour within both the paid and the unpaid economies in Chile, these processes are more likely to have a negative impact on women rather than men. The analysis here has highlighted the particular difficulties faced by informal workers, many of whom are women, and examined some of their responses to this situation. It is clear that further research and empirical evidence is urgently needed to fully understand the impact of these processes and to help develop more equitable policies, thus ensuring that health services are accessible to all. While in some parts of the world community' based insurance schemes have been introduced in an attempt to respond to the needs of informal workers, it is not clear that these really provide a long-term viable solution. Policy makers need to think beyond the conceptual divide between informal and formal workers and identify policies that respond to the realities of all workers' lives in the current economic context. Finally, policy makers must ensure that such policies are gender-sensitive and that women's roles in reproducing and labour for the economy are also recognized.

NOTES

1. The creation of the Sistema Nacional de Salud (SNS) in Chile in 1952 was one of the most significant moments in the development of the health system, as it provided around 75% of the population with free access to health provision for the first time. Prior to this, health was provided through a series of social security funds in the case of workers and their families, although dependent women were only able to access free health care services during pregnancy. The creation of the SNS brought together all pre-existing provision into one new organization and workers' contributed 4.5% of their salaries to the system. Resources for the SNS were predominantly derived from central government funds (around 60%), worker's contributions (around 20%) and other income received directly by the health agencies accounted for the remaining 20%. The SNS guaranteed health care for all workers, their immediate dependants and for indigents (Gideon, 2001). While the system was gender biased in terms of the inherent 'male breadwinner' bias, if women were incorporated into the paid labour force they had the same rights to the system as all male workers. The solidarity function of the SNS, whereby risks were spread across the working population, was a central tenet of the scheme.
2. http://stone.undp.org/hdr/reports/global/2003/indicator/cty_f_CHL.html (accessed February 2006).
3. http://www.gobiernodechile.cl/plan_auge/que_es_auge.asp (accessed February 2006).

4. Other factors have also contributed to this process – see Carr and Chen (2002) for further discussion of this.
5. The NGO responsible for conducting the research in Chile was AnaClara, but following internal changes a new organization, CECAM (Centro de Educación y Capacitación a la Mujer) has now emerged and is responsible for continuing this work.
6. Interview with Miriam Ortega Aaraya, CECAM Regional Coordinator, 25 July 2003.
7. http://www.paho.org/English/DD/AIS/cp_152.htm (accessed February 2006).
8. Interview with Miriam Ortega Aaraya, CECAM Regional Co-ordinator, 25 July 2003.
9. Interview with Dr Salcedo, Director of Santiago Sur Health Service, May 1998; interview with Dr Juan Ilabaca, July 2003, Director of Primary Health Care, Santiago Sur Health Service.

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RÉSUMÉ

Une Analyse de Genre dans le Travail de l' 'in' formalisation et l'accès au Marché de la Santé au Chili

Des réformes dans le secteur de la santé en Amérique latine remplacent le concept de risque au niveau de la population par des approches plus individualisées à l'accès aux soins de santé et des arrangements d'assurance maladie qui ont été recommandés par la Banque Mondiale comme un moyen d'aider les gens pauvres à prévenir les risques sanitaires. Pourtant, dans le même temps, les abaissements des normes de travail et la croissance d'ouvriers informels signifient que, pour un nombre croissant d'ouvriers, contribuer à une assurance maladie n'est pas faisable. Avec l'exemple du Chili en tête, cet article examine les dimensions de genre de ces processus et souligne les façons dans lesquelles la division de sexe au travail signifie que les femmes sont affectées plus défavorablement que les hommes.

RESUMEN

Un Estudio de Género Sobre la Informalización del Mercado de Trabajo y el Acceso a la Salud en Chile

Las reformas en el sector de la salud en Latinoamérica están reemplazando el concepto de riesgo compartido por enfoques individualizados de acceso al cuidado de la salud y por seguros privados que han sido recomendados por el Banco Mundial para ayudar a los pobres a prevenir los riesgos de enfermedades. Sin embargo, al mismo tiempo, la degradación de las normas laborales y el aumento de trabajadores no cualificados implican que no sea posible aumentar el número de obreros capaces de acceder a un seguro privado de salud. Tomando como ejemplo el caso de Chile, este artículo examina las dimensiones de género que afectan a estos procesos y demuestra de manera efectiva cómo la división sexual del trabajo afecta de manera más negativa a las mujeres que a los hombres.

BIBLIOGRAPHICAL NOTE

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